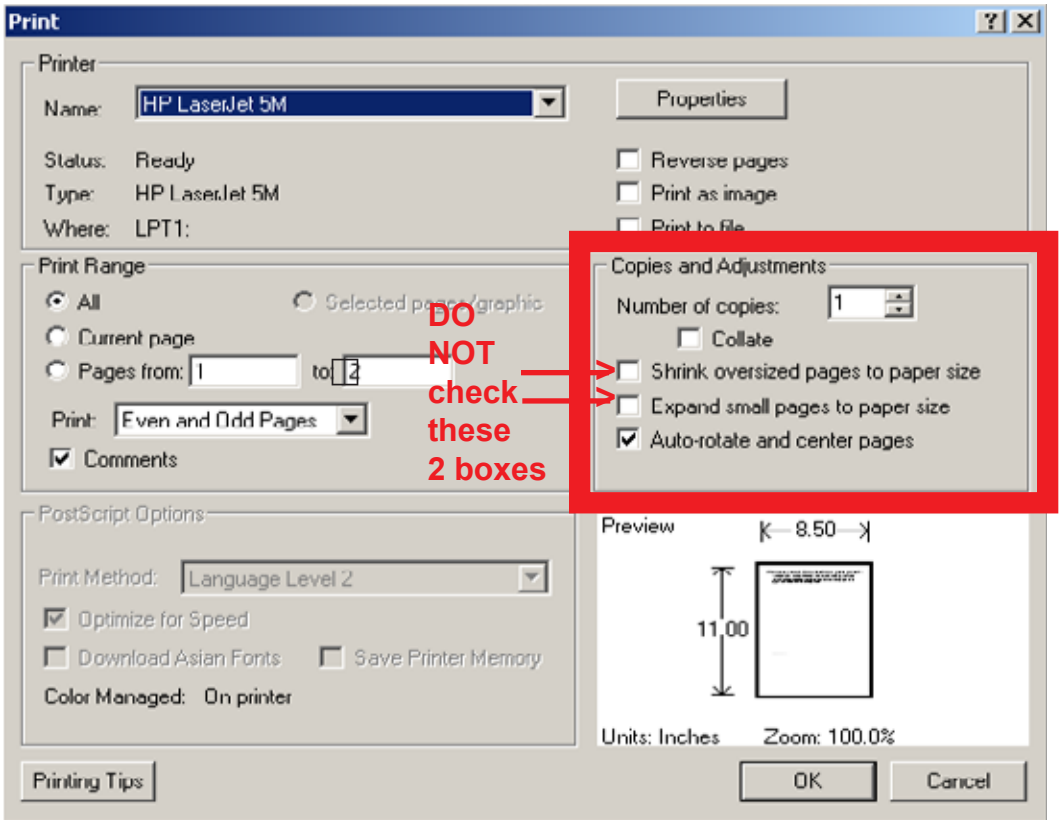
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or



DOH 600-033 (REV 3/2006)

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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Dispensing Optician Re-Examination Application Packet

1. 647-069 ... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 647-062 ... Dispensing Optician Re-Examination Information/Instructions ..... 1 page
3. 647-015 ... Dispensing Optician Re-Examination Application ..... 2 pages

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Dispensing Optician—Re-Exam

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 647-069 (REV 4/2006)

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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Dispensing Optician Re-Examination Information/Instructions

Any candidate obtaining a score of less than 70 percent in any section will only be required to retake the section(s) not successfully completed. Candidates failing an examination section(s) may retake the section(s) at the next examination date. Applications for examination or examination retakes are due to the Department of Health sixty (60) days prior to the examination date.

Applicants failing to successfully pass all sections of the examination within three (3) consecutive regularly scheduled examinations shall be required to re-examination on all three (3) sections.

Examination Fees And Cancellation

All examination fees are non-refundable. If an applicant is unable to attend his or her scheduled examination, and notifies the dispensing optician program in writing at least seven (7) days prior to the scheduled examination, the candidate will be rescheduled at no charge. Otherwise, the fee will be forfeited; however, emergencies may be considered.

Fees:

$200.00 ..... Full Examination

25.00 ..... Basic Concepts Re-examination

25.00 ..... Contact Lens Re-examination

50.00 ..... Practical Re-examination

Candidates may contact the HPQA Customer Service Center at (360) 236-4700 for a re-examination application packet. **A completed application indicating the portion(s) of the examination being taken along with the appropriate fee should be mailed to the following address at least 60 days prior to the exam date:**

The Department of Health
Dispensing Optician Program
P.O. Box 1099
Olympia, WA 98507-1099

Any supporting documentation or cancellation notices should be mailed to:

The Department of Health
Dispensing Optician Program
P.O. Box 47870
Olympia, WA 98504-7870

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Dispensing Optician Re-Examination Application

Credential #

I am applying for the following portions of the Dispensing Optician exam:

☐ **Full Examination** ☐ **Written Basic Optical Concepts** ☐ **Written Contact Lens** ☐ **Practical Examination**

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by applicable fee which is nonrefundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW)
( )	— —

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)	MAIDEN NAME
☐ Female ☐ Male	/ /		

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list other name(s):

2. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐

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2. Personal Data Questions *(continued)*

	YES	NO
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

	YES	NO
5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

3. Applicant's Attestation

I, _____ , certify that I am the person described and identified in this
NAME OF APPRENTICE

application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act. I attest that I have answered all questions truthfully and completely and the documentation provided in support of this application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I have not been convicted of any criminal charges and/or suffer from any physical or mental conditions, which would jeopardize the quality of care rendered by me to the public. I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my credential to practice in the State of Washington.

_____
SIGNATURE OF APPLICANT

_____
DATE

Official Use Only

Washington State Records Center